Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: VISTA HOSPITAL OF DALLAS 4301 VISTA ROAD PASADENA TX 77504	MFDR Tracking #: M4-10-0052-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: LM INSURANCE CORP. REP. BOX #: 28	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…With Regard to the charges at issue in this dispute, there is no evidence presented by the Carrier that the prices billed were not Provider's usual and customary charges (which the Provider must bill under Division rules) or that the final price was not fair and reasonable. Therefore, the Carrier is required to reimburse Vista Hospital of Dallas $10,988.88 pursuant to the Outpatient Fee Guideline, which will result in a fair and reasonable reimbursement for the services provided to the injured worker. The Carrier made a partial payment of $5,747.78. Therefore, the Carrier is required to reimburse Provider in the additional amount of $5,241.10, plus any and all applicable interest…"

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill
3. EOBs
4. Medical Reports
5. Total Amount Sought $5,241.10

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…We have received the medical dispute filed by Vista Hospital of Dallas for services rendered to [injured worker] for the 09/02/08 date of service. The bill and documentation attached to the medical dispute have been re-reviewed and an adjustment has been made to allow for the following: CPT 29888 ACL repair paid at $5,747.78 OPPS Medicare # 200% CPT 29876 (synovectomy 2 or more compartments) $1,809.60 reduced 50% per multiple procedure rule OPPS Medicare @ 200% CPT 27385 (SUTURE QUADRICEPS/HAMSTR) paid at $1,337.31 reduced 50% per multiple procedure rule OPS Medicare @ 200% CPT 29999-59 denied resubmit with a more descriptive code. (B207). However as stated above, this appears to be duplicate billing of the quadriceps repair CPT 27835 since there is no procedure documented that warrants the use of an unlisted code and the attached surgeons bill shows 27835 with the 29999/59. CPT 20926 (billed for placement of autologous soft tissue transfer platelet gel patch denied as because there is insufficient evidence in the published, peer-reviewed literature supporting the medical efficacy of this procedure. The total additional paid was $3,146.91 with interest in the amount of $101.30 for 283 days. Denied overnight pulse ox code 94762 as DC dos…

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
09/02/2008	HCPCS Codes J3491, A4649 x 2 and CPT Codes 29876, 29999, 27385, 20926, 99144, 99205, 99234, 94762	$6333.57 (APC) +$0.00 (Outlier Amount) = $6333.57 (OPPS) x 200% = $12,667.14 (MAR) - $4,660.95 (Total paid by Respondent) = $8,006.19	$5,241.10	$1,042.00
			Total Due:	$1,042.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. According to the Table of Disputed Services all CPT Codes/Revenue Codes are being disputed with the exception of CPT Code 29888 billed under Revenue Code 360; this code is a Status T code. Status T codes are defined as outpatient significant procedures subject to multiple procedure discounting. The highest paying Status T APC is paid at $100%; all others are paid at 50%. The amount calculated and ordered does not reflect the payment amount for this particular code.

2. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reasons. Submitted EOB did not list any ANSI codes:
   Explanation of benefits with the listed date of audit 11/11/08:
   - 16,B406 – Documentation not submitted or insufficient to accurately review this bill;
   - 150, Z652 – Recommendation of payment has been based on a procedure code which bets describes services rendered;
   - 42, U634 – Procedure code not separately payable under Medicare and or Fee Schedule Guidelines;
   - D20, B291 – This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed;
   - 97, U454 – This office visit is included in the value of the surgery or anesthesia procedure. If a minor procedure performed after exam and decision-making, please submit supporting documentation; and
   - 16. B207 – This is an unlisted procedure. Pease resubmit with a more descriptive code.

   The Requestor submitted the initial explanation of benefits only.

3. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"

4. Pursuant to Rule §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

5. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.

6. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:

   (1) No contract exists;

   (2) MAR can be established for these services; and

   (3) Separate reimbursement for implantables was *NOT* requested by the requestor.

7. HCPCS Code J3490, billed under Revenue Code 250; A4649, billed under Revenue Code 270; A4649, billed under Revenue Code 272 and CPT Codes 99144, billed under Revenue Code 370 and 94762, billed under Revenue Code 460 have a payment status of "N." Status "N" is used for services or procedures included in the APC rate, but not paid separately as these are packaged items. As a result, the amount ordered is $0.00.

8. CPT Codes 29876, 29999, and 27385 were billed under Revenue Code 360. These CPT codes have a payment status code of T. Status T codes are considered to be outpatient significant procedures subject to multiple procedure discounting. The highest paying Status T APC is paid at 100%; all others are paid at 50%. CPT Code 29876 has an error code of 040. Error code 040 is defined as, "This comprehensive procedure includes one or more components which require a modifier. The Requestor did not attach a modifier. The maximum allowable reimbursement for CPT Code 29999 is $2,850.78, this amount includes the APC plus Outlier times 200%. The maximum allowable reimbursement for CPT Code 27385 is $1,337.30; this amount includes the APC times 200%. As a result, the amount ordered for CPT Code 29999 and 27385 is $1,042.00.

9. CPT Code 20926 was billed under Revenue Code 360. This code has a payment status of T. Status T codes are considered to be outpatient significant procedures subject to multiple procedure discounting. The highest paying Status T APC is paid at 100%; all others are paid at 50%. The definition of CPT Code 20926 is tissue grafts, other (eg, paratenon, fat, dermis). The Respondent, in their position statement, states that they denied payment because there is insufficient evidence in the published, peer-reviewed literature supporting the medical efficacy of this procedure. The injured worker's surgeon, Dr. John McConnell, received preauthorization for "Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)"; as the Requestor did not submit a copy of the preauthorization request it is unknown if the surgeon requested this procedure as part of the preauthorization request process. The Requestor has not submitted documentation to support this procedure was preauthorized. In accordance with 133.308, Medical Fee Dispute Resolution does not have the authority to adjudicate medical necessity disputes; therefore this code will not be reviewed.

10. CPT Code 99205 was billed under Revenue Code 710. The CPT Code has a payment status code of V. Status V codes are defined as "Clinic or Emergency Department visit; may include ER physician or personal physicians." This code also has an error code of 021. Error code 021 is defined as "A medical visit was billed on the same days as a APC procedure, without using Modifier 25. As a result, reimbursement is $0.00.

11. CPT Code 99234 was billed under Revenue Code 760. The CPT Code has a payment status code of B. Status B codes are defined as "Not recognized by OPPS on Bill Type 12X, 13X or 14X; an alternate CPT/HCPCS code may be available." This code also has an error code of 062. Error code 062 is defined as "While this code is not recognized by OPPS, alternate codes may be. Consider rebilling the claim." As a result, the amount ordered is $0.00.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is $1,042.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311
28 TAC Rule §134.403
28 TAC Rule §133.305
28 TAC Rule §133.307 and §133.308

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019, the Division has determined that the requestor is entitled to additional reimbursement in the amount of $1,042.00 for the services involved in this dispute.

		May 11, 2010
Authorized Signature	Auditor III, Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.